Introduction

Years of financial and economic decline has affected the District government's ability to provide sufficient funding for health and human services. As a result, services to special needs populations -- such as children in poverty, substance abusers, juveniles in the justice system, the homeless, mentally and physically disabled, and seniors -- have suffered.

The most dramatic outcome of the District's inability to meet the needs of its most vulnerable citizens occurred when the Child and Families Services Agency and the Mental Retardation and Developmental Disability Administration went into federal receivership in 1995. During this period, recreation programs declined, few programs supported academic achievement, limited programs provided safe havens for children while parents work, teen pregnancy increased, infant mortality increased, and poor school performance became the expectation rather than the exception.

Recognizing the extent of these challenges, this paper focuses on seven issues:

- **Children in Poverty:** National "child/youth well-being indicators" reported by the Annie E. Casey Foundation, DC Agenda, and Children's Defense Fund place the District's children and youth last in national rankings. High percentages of children living in poverty, infant mortality, teen birth rates, and child abuse and neglect are among the challenges.

- **Juvenile Justice:** As of December 2001, 1,340 juvenile cases were pending in Superior Court; 100% of those juvenilesare African American or Latino. The justice system lacks cohesive, coordinated and appropriate services to address the multiple needs of these children.

- **Homeless Populations:** The risk for low to middle income people to become homeless has increased greatly as national and local economic forces have placed a greater fiscal burden on these residents.

- **Substance Abusers:** Approximately 60,000 residents – more than 10 percent of the District's population – are addicted to illegal drugs or alcohol, compared to 4.8 percent of the U.S. population.

- **People with Disabilities:** People with disabilities of all ages require greater support to remain -- or become -- productive members of society.

- **Seniors:** As people continue to live longer and the senior population increases, the quality and cost of care in a variety of settings will become more important. This population increase is occurring as the number of professional caregivers is decreasing.

- **People with Mental Health Disability:** Mental health services in the District must be improved to provide streamlined, quality and accessible services.

What We Know

National "child/youth well-being indicators" reported by the Annie E. Casey Foundation, DC Agenda, and Children's Defense Fund place the District's children and youth last in national rankings. Challenges include high percentages of: children living in poverty, infant mortality, teen sexuality and birth rates, and child abuse and neglect.

Based on 2000 Census data, almost one-third (31.7%) of the District's children and youth live in poverty.[1] This number has increased 24 percent since 1990, while poverty in the surrounding suburbs stands at 5.8 percent. Washington DC had the highest percentage increase in children in poverty among the U.S. cities that experienced the greatest poverty rate increases between 1990 and 2000.Programs such as Head Start have not been able to keep up with the increased need for this program. While infant health and life expectancy have improved marketedly in recent years (the number of low birthweight babies has decreased from 1,214 in 1995 to 913 in 2000; and the number of infant deaths has decreased from 235 to 91 between 1991 and 2000), the number of low birthweight babies and infant deaths are still nearly twice the national average. In 2000, the rate for low birthweight babies in the District was 11.9 percent, compared to 7.1 percent nationally; and the rate of infant deaths per 1,000 live births was 11.9% in the District (vs. 6.9 percent nationally).

The Centers for Disease Control's Youth Risk Behavior Survey documents that District youth far exceed national averages in all measures of sexual activity. The following table summarizes the indicators for the year 2001.

Indicator	DC	US
% of DC high school students who have had sexual intercourse	61.6	45.6
% of DC high school students who have had intercourse before age 13	16.6	6.6
% of DC high school students with 4 or more sexual partners	23.8	14.2
% of DC high school students who are currently sexually active	41.1	33.4

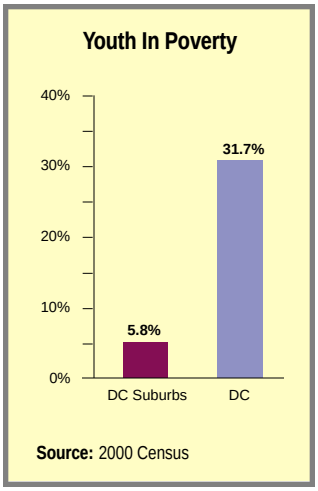
Not surprisingly, the teen pregnancy rate stands at nearly twice the national average and have not declined. In 1998, the rate was 86.7 per 1,000 live births for females aged 15-19, compared to 51.1 nationally; in 1999, the rate was 83.5 per 1,000, compared to 49.6 nationally. While the rate dropped in 2000, the decrease is deceptive because there was a corresponding drop in the number of females in this age range (the birth rate remained essentially the same).

The District now is able to track the number of children suffering abuse and neglect, following the introduction of a new automated data system in October 1999. The previous manual system did not allow comprehensive analysis or reporting. From 2000 to 2002, the number of supported child abuse cases increased from 352 to 701 and the number of supported neglect cases increased from 883 to 1062. Because of the switch from manual to automated tracking and changes in policies related to intake, investigation and placement, year-to-year changes in numbers should not be interpreted as trends because several factors may affect the data: improved reporting and tracking, increased investigations, or increase in family breakdowns. However, these data are worth monitoring and, as data tracking becomes more sophisticated, the system will allow the District to analyze and interpret trends.

[1] Poverty is defined using US Census Bureau poverty measures. In 1999 (the year utilized for the 2000 Census) the poverty threshold for one person under 65 years old was $8,667; for a parent with one child under 18 years old - $11,483; and for a family of four with two related children -$16,895. www.census.gov/hhes/poverty

As of December 2001, 1,340 juvenile cases were pending in Superior Court. All of these cases involved African American or Latino youth and take place in a the justice system that lacks cohesive, coordinated and appropriate services to address the multiple needs of these children.

While African American and Latino youth make up 85 percent of the District's under-18 population, these racial and ethnic groups account for all of the population involved in pending cases in the juvenile justice system. Geographically, the majority of juvenile bookings are from Wards 6 and 8. While these statistics are of deep concern, the juvenile system itself is plagued with problems:



- Youth offenders in the District must interact with several federal and local agencies at different points of the juvenile justice system. Services to these youth generally are lacking or duplicated; they are not always youth-specific, and the full range of social services available to youth are not effectively monitored.

- Additionally, a discrete Family Court system has never existed in the District (although it is currently being formed). The laws governing juvenile sentencing does not provide judges with the flexibility to promote rehabilitation and treatment for youth who are sentenced as adults. A study suggests that "blended" sentencing would decrease by half the number of juveniles who are incarcerated after 21[2]

- After their release, many youth who have been through the juvenile justice system have expressed dissatisfaction with the lack of structured activities (e.g., recreation and after school programs) and gaps in aftercare services. In a 1998 study of juvenile crime in certain areas of DC, Marcia Chaiken [3] found that most boys who were involved in crime had very few structured activities after school, while those youth who were involved in sports and other recreational activities after school had lower rates of crime involvement.

The risk for low to middle income people to become homeless has increased significantly as national and local eco - nomic forces place a greater fiscal burden on these residents.

A downturn in the economy, exacerbated by the September 11 terrorist attacks and the stock market downturn, has meant that a segment of the population is facing a higher risk of layoffs, homelessness and marginal housing as they attempt to avoid the shelter system.

Increases in housing prices and stepped-up efforts at housing code enforcement also have affected this population. Residents of more than 600 public housing units have been displaced as an already-inadequate number of units have been demolished and only partially replaced through the HOPE VI program. Thousands of people have avoided shelters by moving into already-overcrowded accommodations with relatives and friends. These situations are sustainable for only short periods of time and do not represent a permanent solution.

While the District is attempting to replace aging and makeshift housing for the homeless, the increasing numbers of homeless people makes even this effort insufficient to meet current and future demand. Moreover, the nation is experiencing an increased backlash against homeless populations. In the District, a group of local residents is lobbying restaurants to stop feeding homeless individuals so as to discourage their presence in the neighborhood.

[2] Blue Ribbon Commission Report on Youth Safety and Juvenile Justice Reform, p. 131
[3] Chaiken, M.R. Violent Neighborhoods, Violent Kids. (Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, March 2000).

Approximately 60,000 residents – more than 10 percent of the District's population – are addicted to illegal drugs or alcohol.

The statistics on substance abuse among District residents are disturbing. The District's drug and alcohol addiction rate, of approximately 10 percent[4], is twice as high as the nation's rate of 4.8 percent.[5]

Furthermore, many District residents suffer from multiple social problems in which addiction plays a role. Addressing these co-occurring crises and disorders must also be a focus, because:

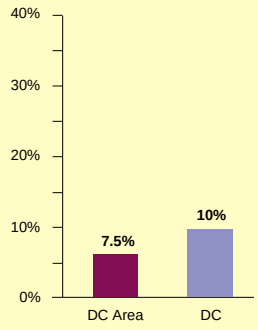
- 85 percent of foster care placements are connected with substance abuse.
- More than half of all adult males who were arrested in the District tested positive for illicit drug use.
- 35 percent of the homeless population has chronic substance abuse problems.
- 27 percent of the cumulative reported AIDS cases in the District are related to intravenous drug use.

Youth are not immune to substance abuse, as 9.6 percent (or 3,229 of the District's 33,639 youth ages 12-17) use illegal substances and, therefore, need alcohol, tobacco and other drug (ATOD) intervention and treatment services.

People with disabilities of all ages require greater support to remain -- or become -- productive members of society.

The largest obstacle in addressing substance abuse is the need to close the "treatment gap" between the city's drug treatment capacity and the numbers of addicts seeking help. Fewer than 10,000 people, or 17 percent of the estimated 60,000 addicted persons in the District received APRA funded treatment in 2001. This "treatment gap" hits particularly hard with adolescents who seek help and require residential treatment. This gap is further widened by the lack of coordination among District agencies, which in turn creates duplication of effort and recurring consumption of services by the same individuals.

Percentage of Youth (5-20) That Are Disabled



Source: 2000 Census

Twenty-two percent of the District's population between the ages of 21 and 64 has a disability. Of this group, 36,067 (or 29%), are unemployed. To assist these individuals in becoming productive members of society, a number of services are crucial. Specific needs related to this general issue are affordable, accessible housing and accessible public transportation.

Affordable, accessible housing: The District has a significant unmet need for subsidized accessible housing, Of the 10,460 public housing units in the District, only 1.8 percent (191) are classified as accessible.[6]

Accessible public transportation: Although the District has been a pioneer in providing accessible public transportation to more than 19,000 District riders with disabilities, the system is frequently plagued with shortages of trains and breakdowns of elevators and escalators. The District is the only jurisdiction in the metropolitan area that does not have accessible van or taxi services. District residents with disabilities must register with the taxicab commission to use Maryland or Virginia accessible van services[6]

[4] Based on a combination of data from Addiction Prevention and Recovery Administration's ***2000 Household Survey on Substance Abuse in the District of Columbia*** plus estimates of addicted individuals who are incarcerated, homeless, institutionalized, living in dormitories and on military installations.
[5] The federal government's ***National Household Survey on Drug Abuse***.
[6] District of Columbia Housing Authority, with data cited in Washington Post, "Disabled Sue District for Barrier-Free Housing: Shortage of Units Said to Violate Law," March 28, 2001, page B01.

According to the 2000 Census, one in 14 children in the Washington D.C. area is disabled and 10 percent of the Districts' youth aged 5-20 suffer from some kind of disability, which is the highest percentage in the metropolitan region. This population faces a host of service challenges, primarily related to access to job training and education:

- It is estimated that only one-third of young people with disabilities receive the job training they need.[7] Major gaps exist between the careers that people with disabilities desire and their level of functioning.
- Young people with disabilities have significantly lower rates of participation in post-secondary education than other youth. The Social Security Administration has found that many young people with disabilities entering the Supplementary Security Income (SSI)/Social Security Disability Insurance (SSDI) programs are likely to remain for their entire lives.
- Many Special Education students are enrolled in non-graded classes that result in the "Certificate of IEP Completion." The IEP Certificate, however, has no relevance to employment or admission to institutions of higher learning or technical training.

As people continue to live longer and the senior population increases, the quality and cost of care in a variety of settings will become more important.

This population increase is occurring as the number of professional caregivers is decreasing.

The 2000 Census indicates that 69,791 senior citizens (defined as those over 65 years of age) are living in the District (making up 12.2 percent of the District's population), a decrease of 10.2 percent from 1990. The senior population had increased steadily from 1960 to 1990, while the District's total population was falling, but this trend has reversed. However, the number of people within the 75+ and 85+ age groups has continued to grow, at 2.1 percent and 14.4 percent, respectively.

While 95 percent of District seniors live at home (as opposed to an institutional setting), 43 percent are coping with a disability that affects one or more activities of daily life. The waiting list for subsidized home care grows daily as more than 425 seniors await the service.

Other issues facing this segment of the population include the inability to qualify for Medicaid, chronic diseases, and the growing need for caregivers.

Many seniors who need Medicaid service[8] cannot meet the program's financial or level of care eligibility requirements.

Medicaid is also having difficulty finding providers willing to offer some of the waiver services at the current reimbursement rate.

Chronic diseases of the aging can be managed, delayed, and sometimes prevented to eliminate costly and premature institutionalization and disability. It costs the District more than $4,000 a year to provide in-home care services to a senior and more than $63,000 for skilled nursing facility care. Working through the Office on Aging's wellness centers and programs, the District can place an emphasis on preventing disease and promoting health to keep seniors healthier and more independent for a longer time.

Increasing numbers of seniors may not qualify for skilled residential nursing care but still need assistance in performing activities of daily living.

Consequently, the demand for in-home care has increased. Many of these seniors do not qualify for Medicaid and may not be able to afford home care. Further exacerbating the situation is the difficulty in attracting and retaining qualified personnel to enter the low paying field of home health care.

[7] US Department of Education, National Center on Education Statistics, The Condition of Education 2000 in Brief, Jeanne H. Nathanson, Washington DC, US Government Printing Office, 2001 and Department of Education, Office of Special Education and Rehabilitative Services, Twenty-second annual Report to Congress on the Implementation of the Individuals with Disabilities Act, Washington DC, US Government Printing Office, 2000.

[8] Medicaid offers personal care services through its traditional program (as well as case management and other home care services) through its waiver program.

According to the Alzheimer's Association, 75 percent of home care is provided by family members and friends. Support of informal caregivers is particularly important given the shortage of professional and paraprofessional caregivers in the workforce. These increasing burdens require an expansion of caregiver support services to ensure that caregivers can continue to meet the needs of the elderly population.

Mental health services in the District must be improved to provide streamlined, quality and accessible health care services.

Half of the Department of Mental Health's clients also have addiction, health and mental health disorders. This creates a greater need for staff training and interagency collaboration, as staff is stretched to help citizens who have a history of substance abuse, are homeless, or have a criminal history, HIV/AIDS, or mental illness.

More than 68 percent of the District's population are people of color or ethnic minorities. These groups experience access and quality barriers to service including: (1) mistrust and fear of treatment, (2) racism and discrimination, (3) differences in help-seeking behaviors, and (4) differences in language and communication. People who provide mental health services at every level should be trained in cultural competence and, more generally, contracts should be awarded for culturally specific services.

There are also serious challenges in providing mental health services to children. More than five percent of the District's children (or approximately 6,300) experience serious emotional disturbance and many of these youngsters are inappropriately placed in non-treatment settings. Children with mental health challenges and their families need "wraparound" or comprehensive services in an environment most likely to strengthen and maintain the family unit. The service system for children involves seven agencies and requires a greater sharing of resources and coordination among agencies. Information is not organized in formats that can be shared and there are no formal coordination structures, creating duplicated services or gaps in service.

There are 425 youth living in out-of-home and/or out-of-state placement facilities due to serious emotional disturbance. Hundreds more are at risk of being placed out-of-home because of the lack of services in the community and the lack of coordination among agencies that serve this population

Policy Implications

Children in Poverty: The District should focus on prevention and intervention for families in poverty, seeking to coordinate a system of seamless services that support the entire family, fostering interagency collaboration and information sharing, and addressing family needs before they reach critical mass. By "frontloading" services, reliance upon social service systems can be reduced.

Youth in the Juvenile Justice System: The juvenile justice system should offer a range of supportive, rehabilitative and sentencing options: (1) to promote youth development wherever possible; (2) to ensure that local and federal entities coordinate and exchange information; (3) to provide comprehensive case management to juveniles and their families; (4) to inform the processes and options through research and addressing race and geographical bias; and (5) to implement the Family Court to provide youth-specific interventions.

The District should establish a Youth Services Coordinating Commission with the responsibility for oversight, monitoring and coordination of a policy vision for youth development and juvenile in the District of Columbia. This Commission would: (1) provide a framework for the seamless delivery of services and opportunities to youth; (2) establish and adhere to specific, measurable and time sensitive goals (such as the reduction of school suspensions and truancy, provision of services for underserved youth in various geographic areas of the city); (3) assure the District's compliance with the Jerry M. decree[define] within

two years, along with the timely demolition of Oak Hill Juvenile Detention Center, the construction of a secure and state of the art cottage-like smaller facility and the continued expansion of high quality community based programming and facilities, (4) coordinate policy and outcome based planning across agencies as basis for creation of innovative programs, (5) ensure the collection of youth data from public and private sector agencies.

Homeless Population: The District should provide access to affordable housing to all, including seniors, youth, the homeless, those with health and mental health disabilities, those who are physically challenged, and those who fall below the poverty level. While recognizing the need for some kinds of group housing (such as shelters, drug treatment centers), this vision statement moves toward fully accessible and integrated housing for all, incorporating the formerly homeless into communities and neighborhoods with supports to ensure self-sufficiency, not in identified "homeless" housing.

Substance Abusers: Treatment capacity must be increased significantly, particularly for youth, women, and ex-offenders. It is essential that a seamless and efficient continuum of care be established by improving resource allocation and strengthening collaboration among government entities. Gaps in the treatment continuum and lack of coordination must be addressed. The Mayor's Interagency Task Force on Substance Abuse will address development of a citywide strategic plan for substance abuse and it is strongly recommended that this work continue and that it be fully implemented.

Citizens with Disabilities: It is essential that citizens with disabilities be able to live with self-sufficiency, dignity and access the range of daily living activities. Key among these is (1) affordable, accessible housing, (2) accessible and well-maintained public transportation, with the addition of van and taxi service and (3) increased opportunities for disabled youth to obtain high school diplomas and vocational training.

Seniors: Seniors should be supported in home and community-based settings so they can age with dignity, support, and remain active as long as possible. Initiatives could include establishing wellness and disease prevention programs, expanding the pool of professional and paraprofessional elder caregivers, supporting family members caring for their elders, and providing affordable assisted living facilities for the senior population.

Citizens with Mental Health Disabilities: An effective and comprehensive mental health care system should include early intervention and prevention efforts and provide intensive community-based services that are integrated with related service structures, should allow information sharing among service agencies, and, where possible, should allow client choice and serve clients in the most integrated and least restrictive environments possible, and should be family-based

How the Comprehensive Plan Addresses Special Needs Populations

The Comprehensive Plan addresses health and social services as one broad issue. In terms of social services, the Comprehensive Plan addresses (1) system-wide service delivery, (2) services to some special populations, and (3) the inclusion of community feedback and partnerships in the delivery of those services, with the goals of providing quality services to the most needy and promoting and sustaining self sufficiency.

System-Wide Service Delivery: Section 1002 ("Human Services Delivery System") recognizes the need to improve and coordinate the service delivery system by addressing efficiency and effectiveness (section 1000.4) and increasing accountability and using computerized management information systems (section 1002.2.b). The word "coordinate" occurs throughout the plan (sections 1002.2.h, 1002.2.k) as key to providing comprehensive and seamless services to District residents.

Services to Special Needs Populations: While the plan does not systematically address each population's needs it does mention certain key service recommendations in Sections 1000, 1002 and 1005:

- Homelessness -- "Maintain and improve services for all children and adults in 24 hour care facilities and ensure that victims of homeless are cared for, especially when extreme weather conditions occur." (1002.2.c)

- Mental Health -- "De-institutionalize clients in institutions who require less restrictive levels of care, provide adequate follow-up to monitor their progress, and coordinate the development of alternative placements with public and private agencies." (1002.2.e)

- Child Abuse Prevention -- "Administer Child and Family Services to avoid removing children from their families, whenever possible, and promote the rehabilitation of families undergoing stress." (1002.2.f) and "Prevent or remedy neglect, abuse, or exploitation of children and adults and preserve, rehabilitate, or reunite families making every effort to maintain or place children in permanent residential settings." (1005.2.d)

- Substance Abuse -- "Support the development of adequate alcohol and drug abuse facilities directed toward prevention, control, and rehabilitation." (1002.2.g)

- Seniors -- "Coordinate existing services and policies and provide new services in health, housing, transportation, and recreation including the establishment of multi-purpose senior centers in areas that have a large elderly population and the provision of transportation to and from the centers, to make it possible for the elderly to remain independent in their own homes." (1002.2.h)

- Youth Development -- "Promote health, environmental, and life-style conditions to strengthen the well-being of children and youth." (1005.2.g)

- Citizens with Disabilities -- "Promote conditions to enable handicapped persons to enjoy rich and full lives." (1005.2.h)

Absent, however, is a specific discussion of certain key groups such as youth offenders, youth with disabilities, youth with mental health issues, and ex-offenders.

Inclusion of Community Feedback and Partnerships -- Stated goals of the plan include public and private sectors working together (1000.2), involving community stakeholders to ensure that services respond to identified community needs (1000.3), promoting programs of needed support to enable citizens to maintain dignity and independence (1005.2.i) and empowering those most in need to gain greater influence and control over their lives, communities, and the services within those communities (1005.2.j).

Questions to Consider When Evaluating the Comprehensive Plan

- The plan emphasizes "coordination" in service delivery. Should it be more specific in addressing how to implement that coordination? Should it mandate information sharing, cross-agency collaboration, and technological standards?

- Does the plan comprehensively capture the service needs of special needs populations and provide sufficient guidance in addressing those needs, with documented data and rationale for addressing those needs?

- Does the plan adequately address the consumer in decisions affecting care and service?

- Are the unique needs of children and youth adequately addressed?

- How can under- or non-utilized public facilities and land be used to support the care needs and integration of these populations?
- Does the plan ensure that special needs populations are given the supports they need to live in dignity, independence and self-sufficiency?
- Does the plan place enough emphasis and support on prevention, intervention before crisis, and providing care in a manner that avoids institutionalization and disruption of families and individuals?
- Instead of focusing on areas of deficit, should the plan contain positive and proactive goals such as youth development, prevention of family crisis, or alternative and proactive care responses?